It Is Time for Hospitals to Liberalize Their Visitation Policies
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Because hospitals in Maryland and the District of Columbia have restricted visitors to those patients receiving end-of-life care, pediatric patients, women receiving labor and delivery services, or patients with developmental disabilities, I had assumed that this visitation practice was common throughout the US. But I learned that I was wrong, and that hospitals vary dramatically in terms of how much patient visitation is allowed, especially following inpatient medical and surgical procedures.

The reopening of hospitals to visitors should remain a decision that individual hospitals are allowed to make, but guidance from the US Centers for Disease Control and Prevention (CDC) would be helpful. The public and those who determine visitation policies need to understand the limited risks posed by fully immunized individuals, who have had at least 2 weeks since their second dose of the Pfizer or Moderna vaccine or single dose of the Johnson & Johnson vaccine, or who have had a negative COVID-19 test within the past 24 to 48 hours.

Relevant hospital visitation considerations include whether an individual has been vaccinated and the state vaccination rate. Other important considerations include the COVID-19 test positivity rates in the state, the daily case rate of new COVID-19 cases, and the percentage of available beds that are in use (both general and intensive care unit beds). These numbers vary substantially across the country (and change from week to week) and reflect the current stress on the health care system resulting from COVID-19.

For example, as of May 13, 2021, according to the Johns Hopkins Coronavirus Resource Center, the highest daily rates of positive COVID-19 tests (7-day moving averages) ranged from 18.0% (Idaho) and 14.5% (Iowa) to less than 1% in Vermont and California; however, the positivity rates are a measure of testing capacity that varies considerably from state to state and from county to county within each state.

The argument for maintaining local control over these decisions is not just because of the substantial variations in case rates and new cases being reported as well as the proportion of fully vaccinated state residents, but also because of the different attitudes of state residents toward proper next steps in returning to some sense of normalcy. None of these differences among states, however, changes the positive benefits that family visits can make to the recovery of a hospitalized patient.

Recognition of the importance of hospital visitation for patients started to appear early this year, including a moving commentary that was written by 2 palliative care physicians practicing in Boston, Massachusetts. They wrote, “Much has been said about preventable deaths related to COVID-19. Little has been said about preventable suffering.” They added that the presence of family at the bedside is not an indulgence but “need[s] to be part of the standard of care.”

These palliative care physicians described what may have resulted in an unintended consequence from a policy during the early weeks of the spring surge in 2020 to only allow a brief hospital visit for family members at the end of a patient’s life when patients had decided to transition away from life-sustaining care to comfort care. This policy led the physicians to worry that the policy could have been viewed as a subtle form of coercion.

In another article on the importance improving family access, a critical care physician and an ethicist discussed the profound effects that limited visitor access can have on dying patients and their family members. Although they noted worries about visitors transmitting COVID-19 infections, they had greater concern regarding the negative effects of restrictive visitor policies on both patients.
and their families, including a higher frequency of delirium and anxiety in patients separated from family, as well as the higher risk factors for poor bereavement outcomes for the families if the patient dies. The authors also acknowledged the limited data on the harms of liberalizing visitor policies and the challenges of determining which patients may be in a terminal phase of their illness but noted that liberal visitor policies in intensive care units do not appear to be associated with an increased risk of nosocomial COVID-19 infections.

Since March, hospitals in various parts of the US have begun opening up to regular visitors for non–COVID-19 patients. Since the second half of March, almost all California hospitals have been allowing 2 visitors from the same household at a time as long as social distancing can be maintained. In several other states, such as Massachusetts and Virginia, 1 adult visitor is allowed for non–COVID-19 patients, although Virginia has special rules for obstetrical, pediatric, or end-of-life patients. In Michigan, most hospitals allow 1 visitor and some have allowed 2 adult visitors; however, at least 1 health system has discontinued allowing adult visitors except in special cases because of the spike in COVID-19 cases this spring.

New guidance about best reasonable practices for hospital visitation seems long overdue. Recognizing the importance of visitation to both patients and their families suggests encouraging hospitals to allow most adult non–COVID-19 patients at least 1 adult visitor. With 55% of adults already having received at least 1 dose of vaccine and the US reaching the point where vaccine supply is exceeding demand, hospitals that remain uneasy about visitation can require proof of vaccination or a negative COVID-19 test undertaken within the previous 48 hours. Other hospitals can continue allowing adult visitation as they have. However, not allowing at least a single adult visitor for non–COVID-19 medical or surgical patients seems unreasonable and inhumane.

The CDC is predicting that there will be a sharp decline in new COVID-19 cases by July. As a result, most hospitals should be able to liberalize their visitation rules no later than this summer. But just as several viruses have plagued the world in the relatively recent past—including SARS (in 2003, caused by another coronavirus), Ebola, and COVID-19—another virus may be in the future. Next time, preparation needs to be better with an adequate supply of personal protective equipment, a general response readiness, and by having a more consistent and humane way to determine hospital visitation policies.

ARTICLE INFORMATION

Correction: This article was corrected on May 25, 2021, to replace the first paragraph of the article.

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REFERENCES
